FOR OFFICE USE ONLY



## **MEDICAL BOARD OF CALIFORNIA**

LICENSING PROGRAM

2005 Evergreen Street, Suite 1200
 Sacramento, CA 95815
(916) 263-2382 FAX (916) 263-2567
 www.mbc.ca.gov



## NOTIFICATION OF NAME CHANGE

Please indicate license type below:			Date Received:		
Physician & Surgeon			Enforcement Approval:		
Midwife					
Spectacle Lens Dispenser/Contact Lens Dispenser			Date:		
<b>IMPORTANT</b> : The first line of	the declaration N		•	your name	change.
		<b>DECLARATIO</b>	<u> </u>		
I,			(nar	ne prior to	change)
I, (First)	Middle)	(Last)			
hereby certify that I was original	lly issued and cu	rrently hold lice	nse/registration		
number(s) to practice in the State of California.					
I further certify I have assumed t	he name of:				
(First)	(Middle)		(Last)		
based on one of the following:					
Court Order	Marriage	Naturalizatio	n Dissolution of M	Marriage	
I hereby declare under penalty of all purposes, and this name chang				s my new a	dopted name for
You MUST submit a certified cocopy is submitted, it must be not above:					
• Marriage Certificate • F	inal Dissolution D	Decree • Copy	of Court Order • Na	nturalization	n Certificate

BOTH PAGES OF THIS FORM MUST BE COMPLETED.

This notification will not generate a duplicate certificate. Please submit an application for a duplicate license, if

you wish a certificate reflecting this name change.

PHOTO AREA PHOTO DECLARATION **PASTE A 2" X 3"** PHOTO HERE I hereby declare under penalty of perjury under the laws of the State of California that the photo of me attached hereto, was PHOTO MUST BE RECENT AND MUST taken on or about \_\_\_\_\_. BE OF YOUR HEAD & SHOULDER **AREAS ONLY** Applicant's Signature: SCANNED, ALTERED, OR POLAROID PHOTOS ARE NOT ACCEPTABLE. TELEPHONE **CURRENT ADDRESS OF RECORD** NUMBER (PUBLIC/MAILING ADDRESS) Address: \_\_\_\_\_ City: State: Zip: This is the address that will be displayed on your profile on the Board's Internet Web site. If listing a PO Box, you must also provide a confidential street address. **Confidential Street Address:** Address: City: State: Zip: NOTICE: All items in this application are mandatory; none are voluntary. Failure to provide any of the requested information will result in the application being rejected as incomplete. The information provided will be used to identify the licensee and to verify the licensee's identification under Section 2081of the Business and Professions Code. Licensees have the right to review their application file subject to the provisions of the Information Practices Act. The Licensing Program Chief is the custodian of records. Information in this application may be transferred to other governmental and law enforcement agencies. **AFFIDAVIT** I certify under penalty of perjury under the laws of the State of California that the information provided on this form, including supporting documentation and photograph of me, is true and correct and that I am licensed/registered to practice in the State of California. Applicant's Signature Date **NOTARY** This individual, \_\_\_\_\_\_, has appeared before me, signed in my presence and is identified as the above individual. Subscribed and sworn to before me this \_\_\_\_\_\_ day of \_\_\_\_\_\_\_, \_\_\_\_\_. Notary Public's Signature Telephone Number

NC-1 (Rev. 04-06)

My commission expires \_\_\_\_\_\_. SEAL